OCTOBER 2015

QI . . . UP TO THE MINUTE

AOD

Unless explicitly stated in other portions of the newsletter, only the information in this section will apply to AOD programs.

ICD-10 & SanWITS Recorded Webinar Available!

- *The webinar offered at the end of September for the ICD-10 transition in SanWITS is available on the BHETA website.*
- *Log in to (or create) your BHETA account: http://rod.sumtotalsystems.com/academy/app/SYS_login.aspx?lang=en-US*
- *Use the search tool on the left side of the screen to search for "ICD-10."*
- *Select the webinar called "BHS-ICD 10 SanWITS Recorded Webinar," then click the "Register" button.*
- *When the training is highlighted in gray, select the "Submit" button.*
- *On the final screen, select the "Done" button and the webinar will launch.*
- *For questions or technical assistance, contact BHETA: bheta@mail.sdsu.edu*

Title 22 Amendments Finalized

- *On July 14, 2015, Title 22, Section 51341.1 amendments were made permanent.*
- *The regulation contains definitions, prescribes in more detail how counseling sessions are to be conducted, imposes physical examination requirements, distinguishes an initial treatment plan from an updated treatment plan, and requires treatments to be recorded in more detail. It also clarifies that an LPHA may evaluate a beneficiary to diagnose whether the beneficiary has a substance use disorder; however, it still requires a physician to document approval of each diagnosis by signing and dating the beneficiary's treatment plan.*
- *The County's "Alcohol and Other Drug Provider Operations Handbook" (AODPOH) is being updated to incorporate this information.*

MENTAL HEALTH SERVICES

MH MIS CORNER:

The current turn-around time for access to CCBH after submitting an ARF is 5-7 days. Please remember to enter all requests clearly, and complete the form accurately. If you have any questions or have not heard back from MIS after this timeframe, please call:

(619) 584-5090

ANNOUNCEMENTS

ICD-10 and Cerner (CCBH) Recorded Webinar Available!

- The webinar offered at the end of September for the ICD-10 transition in CCBH is available on the BHETA website.
- Log in to (or create) your BHETA account:
  - http://rod.sumtotalsystems.com/academy/app/SYS_login.aspx?lang=en-US
- Use the search tool on the left side of the screen to search for "ICD-10."
- Select the webinar called "BHS-ICD 10 DAS Recorded Webinar," then click the "Register" button.
- When the training is highlighted in gray, select the "Submit" button.
- On the final screen, select the "Done" button, and the webinar will launch.
- For questions or technical assistance, contact BHETA: **bheta@mail.sdsu.edu**

- FAQs from these webinars were sent to programs at the beginning of the month, and the PowerPoint slides and handouts are posted to the Optum website on their home page.

ICD-10 Crosswalk

- The ICD-10 Crosswalk created by QM is meant as a tool to assist with ICD-10 implementation.
- It is not a definitive resource of all ICD-10 codes.
- You are not "limited" to use only the diagnoses from the crosswalk.
- As is our current standard, providers are responsible to select appropriate diagnosis codes based on criteria for that diagnosis. If you don't find something on the crosswalk, consult a resource such as the DSM-5, which has ICD-10 codes attached to each DSM diagnosis.
- If you find a code that is not active in CCBH, contact QI Matters to request that it be activated.

Newly Hired Staff and CCBH Training

- We have noticed that newly hired staff are having difficulty with integrating and retaining the clinical concepts, documentation standards and technical aspects of learning CCBH. This is especially evident when new staff are taking Assessment training immediately followed by Client Plan/Progress Note training, and they have had little to no exposure to the clinical or documentation standards required for these processes.
- To assist new staff better master CCBH tasks, the sole focus of these trainings will be to demonstrate competency in navigation and use of the electronic health record system.
- Starting November 1, 2015, trainings will be provided by technical staff only.
- For this reason, the expectation is that (at a minimum) program managers fully orient new staff to the BHA and Client Plan process prior to their training in CCBH.
- To support more successful understanding by new or returning staff of the link between clinical assessment and client plans, QM has developed documentation training webinars for both the Children and Adult Systems of Care**.**
- It is best to have newly hired staff view the full Documentation Training webinars prior to their CCBH training.
- This will allow for newly hired staff to focus more fully on learning the functionality of the CCBH software during the training.
- Program Managers can e-mail QI Matters to request the links to view the Children's or Adult Documentation Training webinars. Make sure to specify in the e-mail which version of the training you are requesting.

Signing the New Diagnosis Form

- There have been some questions about how to sign the new Diagnosis form that was uploaded to CCBH on 10/1/15.
- There are different signatures depending on your level of credential (requiring a co-signature, no signature required, or administrative staff entering information as data entry).
- For step-by-step instructions on how to complete the signatures, refer to the document "ICD-10 DAS Tip Sheet" on the home page of the Optum website.

Client Length of Stay Report

- There is a new report replacing the "Length of Stay" report in CCBH.
- The "Client Length of Stay" report provides data on clients that were open any time during a specific date range.
- The report primarily provides the number of days the assignment is open in CCBH, from the time of intake to the date of discharge.
- To access the report, go to "Client Assignments" → "Client Assignments Reports" → "Client Attendance Report"
- After the "Client Attendance Report" window launches, select the "Load" icon to select the "Client Length of Stay Report" template.

- On the "Selections 1" tab, enter the desired Unit/SubUnit(s).
- On the "Selections 2" tab, enter the desired assignment dates, and select "Print" to launch the report.
- For additional assistance with running the report, contact the Optum help desk at 1-800-834-3792.

Appointment Reminder Calls

- Program Managers – If you are interested in your program using the automated appointment reminder system for your client appointments, e-mail a request to QIMatters.hhsa@sdcounty.ca.gov.

Reminder: Recorded Webinar Sessions for Documentation Training Are Available!

- Do you have new staff that need Documentation Training? Or staff who would benefit from a review of documentation standards?
- There are recorded webinar sessions available for "on-demand" viewing.
- Webinar content is the same as the content covered in "live" classroom sessions
- Program Managers: E-mail QI Matters to request a personalized link. Indicate if you are requesting links for the Adult or Children's version of the webinars.

BILLING

ICD-10 Code Administrative Tasks and Billing

- It has come to the attention that some staff have been claiming time for making the administrative changes associated with ICD-10 code implementation.
- This has usually been in the form of claiming an 800 code for the purpose of accounting for the time it took to review the previous diagnostic information in the chart, and replacing that information with the appropriate ICD-10 code.
- This is considered an administrative task and, as such, is a "not billable activity."
- This means that no service code is attached and no time is claimed.
- The only time it is appropriate to claim time for updating to a ICD-10 code (or codes) is when it is in the context of a direct service (for example, an assessment session), and then it would be a part of the time claimed for that direct service.
- Please void any 800 services claimed for an "administrative only" updating of ICD-10 codes.

DOCUMENTATION STANDARDS

- In the CYF programs that have participated in Medical Record Reviews (MRRs) for the first quarter of Fiscal Year 2015-2016, overall compliance scores of 90 percent or below were noted in the following areas:
  1. Updating Demographic form when changes are reported or, at minimum, annually.
  2. Initial BHA final approval within 30 calendar days of assignment to program.
  3. Presenting problem in the BHA review period documenting medical necessity.
  4. Cultural information in the BHA for the review period documenting a cultural formulation (and whether these factors impact the client's mental health symptoms/access to mental health services).
  5. Clinical Formulation in the BHA for the review period documenting client impairments.
  6. Client plan objectives for the review period are specific/measurable.
  7. Client plan interventions for the review period document frequency.
  8. Client plan interventions for the review period document duration.
  9. Interventions in the client plan for the review period document how intervention will diminish impairment, (or prevent deterioration), or will allow developmental progress.
  10. Risk factors of harm to self/others are addressed in the client plan for the review period.

11. Progress notes document client impairments, the interventions used to address the impairments, and the client's response to the interventions.
12. Progress notes document ongoing risk assessment (for clients identified at risk) and interventions that relate to the level of risk.
13. There is documentation of coordination of care between program and other providers in the progress notes.
14. The Coordination of Care form is completed which evidences coordination (or documented reason why not completed).
15. Time billed is substantiated in documentation.
16. Services are billable according to Title 9.
17. Outcome measures are completed within timeline and entered into database if applicable.
18. For programs providing enhanced services, documentation is in the chart and on the PWB forms.
19. For programs providing enhanced services, client is identified in Client Categories Maintenance with the identifier for "subclass."
20. For programs providing enhanced services, documentation supports that a CFT meeting has occurred within 30 days of eligibility to subclass and at a minimum of 90 days thereafter.

- In the Adult/Older Adult programs that have participated in Medical Record Reviews (MRRs) for the first quarter of Fiscal Year 2015-2016, overall compliance scores of 90 percent or below were noted in the following areas:
  1. BHA updated as indicated or at a minimum annually.
  2. Presenting problem in the BHA review period documenting medical necessity.
  3. Cultural information in the BHA for the review period documenting a cultural formulation (and whether these factors impact the client's mental heal symptoms/access to mental health services).
  4. Within the past year, when a client is discharged from a 24-hour program for suicidal/homicidal crisis, an HRA is documented.
  5. Client was advised to seek a PCP/medical home if they did not have one (in the BHA for the review period).
  6. Clinical formulation in the BHA for the review period documenting client impairments.
  7. Clinical formulation documents proposed plan of care/services in the BHA for the review period.
  8. Client plan was completed/final approved within 30 days of program assignment.
  9. A new client plan was written/final approved as required.
  10. Areas of need in the client plan covering the review period are linked to symptoms/behaviors/level of impairment identified in the BHA.
  11. Client plan objectives for the review period are specific/measurable.
  12. Client plan interventions for the review period document frequency.
  13. Client plan interventions for the review period document duration.
  14. Interventions in the client plan for the review period document how intervention with diminish impairment, (or prevent deterioration).
  15. Risk factors of harm to self/others are addressed in the client plan for the review period.
  16. If substance use disorder has been identified/diagnosed as an ongoing problem, it is addressed on the client plan for the review period.
  17. Physical health needs that have been identified are addressed in the client plan for the review period.
  18. Progress notes document specific integrated treatment approaches for clients diagnosed with a co-occurring substance use disorder.
  19. Progress notes document physical health care is integrated into treatment for clients with physical health needs.
  20. Progress notes document that client was seen within 72 hours of discharge from an inpatient/crisis residential facility.

21. There is documentation of coordination of care between program and other providers in the progress notes.
22. The Coordination of Care form is completed which evidences coordination (or documented reason why not completed).
23. Service code is correct for service documented.
24. Time billed is substantiated in documentation.
25. Services are billable according to Title 9.
26. UM/UR is completed as required.
27. Outcome measures are completed within timeline and entered into database.

- The recorded documentation webinars are a good resource to assist staff in learning and/or reviewing documentation requirements. Program Managers may send a request for these links to QIMatters.hhsa@sdcounty.ca.gov.

Is this information filtering down to your clinical and administrative staff?

Keep them Up to the Minute!

And remember to send all personnel contact updates to **QIMatters.hhsa@sdcounty.ca.gov**